Non-Covered Service Fee Acceptance Form

I_________________________________, a member of __________________wish to obtain and pay for Contact Lens Exam, Contact Lens Fitting, Contact Lens Evaluation, and Contact Lens, a service which is not covered as a covered benefit under the Medicaid/Medicare Program under which I have coverage.

The Eye Clinic has explained to me that I will be solely responsible for the cost of Contact Lens Exam, Contact Lens Fitting, Contact Lens Evaluation, and Contact Lens, which is $________. I agree to accept responsible for payment of $___________. I understand that I am not obligated to pay for the above service if it is late found that the service was covered under the Medicaid/Medicare Program under which I have coverage at the time it was provided, even if Medicaid/Medicare did not pay The Eye Clinic for the service because he or she did not satisfy Medicaid/ Medicare billing requirements.

I acknowledge that I have been given a copy of this agreement.

____
Member's Signature

____
Printed Name

____
Date

For Office Use Only

Date of service / / Member's effective date of coverage with primary payor: / /

∆ Member Received copy

∆ Copy placed in Member's Medical Record